Social Determinants of Health Monitoring, New Zealand

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Context of Monitoring of Social Determinants

• The Treaty of Waitangi (1850) – a framework for thinking about the Crown’s responsibility towards Maori (indigenous New Zealanders)
• Universal education, and health provision, state funded welfare system, some social housing
• Strong interaction with international actions on indigenous health and measurement
• 1970s - onwards intermittent interest in social outcomes reporting
• 1980s – focus on economic change, evidence on social inequalities emerging from academic literature (eg social class gradients in mortality – Pearce et al.) and outputs from Dunedin and Christchurch longitudinal studies.
• Late 1990s – Actions led out of academic Public Health and Maori Health units to grow evidence, collect and report data on inequalities (better data re Maori health, NZ Deprivation index, census mortality studies)
• Programmes primarily focused on smoking reduction, housing and improved access to primary care
• From 2008. Reduced emphasis on social determinants towards targeted approaches and emerging social investment approaches.
Direction setting for the Social Sector

- **Social Sector Chief Executives Forum** aims to create shared responsibility for social outcomes.
- **Better Public Services** goals aimed to create momentum towards better outcomes for New Zealanders through a more joined up government response.

**Better Public Services Areas for Action:**
1. Reducing long-term welfare dependence
2. Supporting vulnerable children
3. Boosting skills and employment
4. Reducing Crime
5. Improving interactions with government

- **Legislation** that require statistical reporting requires reporting of key social (and other) statistics – the Statistics Act, Health Act etc.
- Investment in information systems to improve the data that is available.
An example of integrating action on social determinants and health to address an inequality

**BPS Goal** Reduce the incidence of rheumatic fever by two thirds to 1.4 cases per 100,000 people by 2017

<table>
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<tr>
<th>Name of Activity</th>
<th>Brief Description</th>
<th>Accountability</th>
<th>Target population</th>
<th>Agencies</th>
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| Sore Throat Management Services       | • **Rapid response clinics** Sore throat clinics aim to make it easier for at-risk children and young people to get their sore throats checked and treated, if necessary.  
• **School based swabbing** Provide free sore throat assessment and treatment to children in priority communities. | Standard contract management process                                            | Sore throat management services are delivered to 80% of the target population    | DHB Implementation            |
| Healthy Homes Initiatives             | identify and support families with children at risk of rheumatic fever by coordinating a comprehensive range of interventions for these families to reduce their level of crowding and subsequent risk of rheumatic fever. | Standard contract management process                                            | • 0 – 15 priority RF population  
• Bicillian referrals  
• More than 3 GAS+ tests | DHB Implementation |
| Pacific engagement service           | Pacific Engagement Service for Pacific families through home visits and community events to raise awareness of rheumatic fever and what they can do to prevent it. | No Internal governance Contact: | Wellington and Auckland Pacific People | Pacific health service providers |
| Awareness campaigns                  | Aimed at Māori and Pacific parents and caregivers of at-risk children and young people aged 4-19 years. It uses TV, radio, print, mail drop, digital screens in community settings and online strategies. The 2016 campaign starts May 1 and concludes in August. | No internal governance                                                        | Parents, Caregivers of priority populations - (Māori, Pacific and Quintile 5) aged between 4–19 years | Health lead HPA |
| Partnership with Corrections to provide furniture | In early 2015 the Ministry of Health (MoH) and the Department of Corrections established a joint project to explore the potential for prisoners in Corrections facilities producing goods that could be used to reduce the impact of functional crowding, thereby reducing the risk of rheumatic fever. | No internal governance                                                        | Families/whanau of priority populations -(Māori, Pacific and Quintile 5) aged between 4 – 19 years | Corrections lead Health contribution |
Reporting process

Context

- Historical, Legislative and Information systems
- Leadership from Cabinet and Senior Officials
- Role of Official Statistics system

Current Key Mechanisms

- Key government reports e.g. the Social Report, Health and Independence Report
- Tier one statistics – wide range of statistics that must be produced and released according to rigorous quality standards and independent of political
- Reporting on health targets and better public services targets
- Cascading accountabilities for actions and outcomes using existing contractual mechanisms

Key Challenges

- Keeping the metrics and related collection mechanisms current in a changing environment
- Accountability structures that create momentum for action
- Ensuring disaggregation of metrics for relevant sub-categories and groups
- The dynamic interactions of the social determinants of health mean often difficult to attribute outcomes to any specific actions – need a complex system model.
BPS results, Immunisation and Rheumatic Fever

**Immunisation Coverage for children at 8 months**

- As of March 2015, 93 percent of all eight-month-olds have completed scheduled vaccinations.
- The coverage by ethnicity is: New Zealand European 93.5 percent, Māori 90 percent, Pacific 95 percent, Asian 97 percent and Other 90 percent.
- Dep 9–10 = Deprivation Decile 9–10.

**First episode rheumatic fever hospitalisations, annual rate per 100,000, Māori and Pacific people, 2011–2015**

Source: National Minimum Dataset